# THE MEDICAL FORTNIGHTLY

Vol. XXXVI ST. LOUIS, SATURDAY, SEPTEMBER 25, 1909. No. 6

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## LEADING ARTICLES

### THE EARLY DIAGNOSIS AND THE SURGICAL TREATMENT OF CANCER OF THE STOMACH.*

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HANNIBAL, MO.

There is probably no disease whose early diagnosis is more important or more difficult than carcinoma of the stomach. That it is the most common of all forms of malignant disease, is the statement of Osler[1] before a recent medical meeting in England. According to Rodman[2], of Philadelphia, one-third of all cancers of the body originate in the stomach and that of these more than half arise from neglected gastric ulcers. Cancer of the stomach in so far as it depends on a chronic ulcer for its origin, is a preventable disease. It is probable that two-thirds of the whole number of cases may be so classed.

The frequency with which a chronic gastric ulcer takes on a malignant change, a condition in which the symptoms of ulcer have existed for a period of time and which continue to predominate for some time after the malignant growth begins, renders the diagnosis one of extreme difficulty. Even in those cases of gastric carinoma that have not had their inception in a gastric ulcer, their diagnosis is one of marked difficulty before the tumor has reached a palpable size. Moynihan[3] expresses the opinion that there are no symptoms, and no signs, which either individually or collectively, permit of an assured diagnosis of cancer of the stomach in an early stage. This is a sweeping statement and one that is refuted by skilled internists whose diagnoses of incipient malignancy of the stomach are often brilliant. Moynihan further states that the chemical examination of stomach contents is of little or no value in so far as the early diagnosis of the stomach is concerned. In later cases when a possible diagnosis of malignancy has been made on the clinical evidence, the results of repeated chemical analyses of the stomach contents affords addtional evidence of considerable value.

In investigating any gastric disorder, Mayo's advice is to study the history of the affection, ascertain the size and situation of the stomach, determine the existence and location of pain and tenderness, the presence of a tumor, and if the passage of food is interfered with. Moynihan says that the importance of a history of repeated attacks of indigestion, alike in their origin, course and termination cannot be exaggerated. Such attacks he claims are due to a chronic gastric ulcer, which at last becomes malignant.

The age at which cancer is most likely to appear is after 40 years, but age is less important for the diagnosis than hitherto assumed. Kuttner[4] claims that the wider his experience becomes the larger the number of youthful patients he discovers to have cancer, their youth preventing the correct diagnosis in many cases. A family history of cancer must also be considered.

The loss of muscular strength and weight are among the most constant early symptoms, but bear no definite proportion to the size and position of the growth. These symptoms are liable to occur earlier and to become more pronounced in cases of gastric and hepatic carcinoma than when the disease is situated elsewhere, though there are many exceptions[5]. This is due the destruction of the secreting surface of the stomach and interference with its function, with a resulting interference with nutrition, which is shown by the improvement

*Read in the Surgical Section of the Missouri State Medical Association at the Jefferson City meeting, May, 1909.

in strength and weight that follows gastro-enterostomy, although the growth has not been disturbed. In other cases a toxemia derived from the growth must be held responsible, for the complete failure of nutrition and consequent loss of weight is quite out of proportion to the size of the growth and is in fact independent of its position.

A. Albu[6], of Berlin, lays stress upon the rapid decrease in the body weight in a few weeks or a month as significant of cancer of the stomach and as indicative of its beginning. This history is sometimes difficult to obtain unless the patients attention is called to it by close questioning.

The cachexia of cancer patients is of extreme variability and a most unsafe guide for diagnosis. It is usually extremely late in making its appearance and may be ignored in cases which surgical relief may be hoped for. It may be entirely absent until shortly before death. The blood picture shows usually a dimunition of hemoglobin, a decrease in the number of red cells and a moderate leucocytosis with a high proportion of polynuclear corpuscles.

The enlargement of the supraclavicular glands is not a reliable sign, though much stress is laid upon this by many European observers. The enlargement of the glands at the attachment of the sterno-cleido-mastoid muscles, especially of the left side has been considered positive, but this may be due to inflammatory or other causes.

The most important early subjective symptoms in most cases of cancer of the stomach are loss of appetite, flatulency, general diffuse abdominal discomfort four or five hours after eating. Loss of appetite is an instructive symptom of cancer, especially when there is pronounced repugnance to meat.[7]

Vomiting is not an early symptom.[8] It may be present in a rapidly growing medulary carcinoma of the body of the stomach, or of a carcinomatous ulcer of the pylorus causing early obstruction.

Pain is not marked in early cases. It is a late symptom and therefore its absence is not to be taken as proof against the presence of cancer. In not a few cases it is absent during the entire course of the disease except in cancer of the pylorus. When present it is constant, heavy, dull and boring in character and in contrast to the sharp, paroxysmal and periodic pain of ulcer.

Active hemorrhage occurs late as a rule except in a rapid malignant change of a simple ulcer. In all his experience Kuttner has known of only three cases in which profuse hematemesis was the initial symptom. Moynihan, on the other hand, states that acute cases are not seldom ushered in by an attack of severe hematemesis with or without melena. It is possible that such copious bleeding is dependent upon multiple hemorrhagic erosions. Soft encephaloid tumors ulcerate early and bleed early and freely. Densely growing schirrus cancers bleed late and in small amounts.

On local examination the cases may be divided into three groups.

(a) Those that at an early period are generally negative except in the cases that originate in gastric ulcers and give the symptoms of that disease.

(b) Those that at a little later period the local examination may reveal a simple atony and dilatation of the stomach before the growth is palpable. When dilatation of the stomach with stagnation of the food appears rather suddenly in a patient past 45 years whose previous health and habits have been good, the cause will generally be due to an obstruction in or about the pylorus and in the great majority of cases will be found to be carcinoma.

(c) Those with tumor. Most cases are first discovered when a tumor is present. The failure to detect a tumor of palpable size may result from carelessness on the part of the examiner in neglecting to have a previous thorough evacuation of the bowels and allowing the stomach to become empty before making his examination, having the patient in different positions. A thick abdominal wall or a rigidity of the same may interfere,. The latter is of itself of considerable diagnostic importance in that it is caused either from reflexes resulting from adhesions, or from the dread of causing pain and tenderness. This can be largely overcome by repeated daily examinations causing the abdominal muscles to relax. Palpation is usually more satisfactory in the morning than in the afternoon, when there are apt to be gases in the stomach and intestines. Failure to find the mass may be due to the character of the growth, the small nodular or diffuse infiltration forms being more difficult to feel than the more circumscribed scirrhus tumor.

A satisfactory method of palpating a small deep-seated gastric growth is to have the patient sit in bed, with his feet partially drawn up, leaning and resting his head on the examiner's shoulder, who sitting behind him reaches around the patient and palpates the abdomen from the front. The patient's muscles are thus relaxed and the natural descent of the abdominal organs

often allows a gastric growth to drop downwards and forwards within touch. Hausmann's[9] method consists in pushing the organ back against the posterior abdominal wall and drawing the fingers downward during expiration following a deep inspiration, the procedure being aided by the rising of the stomach and colon during expiration. He claims to be able to palpate the normal pylorus in 18 per cent of the patients examined.

Distension of the stomach with air may render the tumor more palpable except those situated upon the posterior surface and lesser curvature.

The results of chemical and microscopical examinations of the stomach contents for free hydrochloric acid, lactic acid, the presence of the Oppler Boas bacillus, and of the stomach contents and feces for food remnants, bits of tumor and occult blood are collectively of great value in determining the character of the gastric affection at an early period. No one or no two symptoms or signs are characteristic, but from a combination of several a reasonable diagnosis can be made. One of the most important of these tests is the examination for occcult hemorrhage. This gives a positive result both in ulcer and in cancer, but occurring in the latter in a much larger percentage of cases.[10] Before examining for occult blood the patient must be strictly prohibited form eating meat or flesh food for a period of three days before making the test and must be on an exclusive milk or vegetable diet in order to avoid errors. Either the benzidin or the aloin test may be used. A positive response indicates a probable destructive or ulcerating process, and repeated negative findings exclude cancer with almost absolute certainty.[11]

The diminution or absence of free hydrochloric acid is not of itself significant of gastric carcinoma, as this may occur in many conditions such, as gastritis, jaundice, pernicious anemia, atrophy of the glands of the stomach, tuberculosis, etc. It is diminished in old age, a fact that must be considered in examining for cancer of the stomach in individuals advanced in years. Diminution or absence of free HCl in the stomach occurs with carcinoma of other parts of the body. In 29 cases of carcinoma, not of the stomach, examined by Friedenwahl[12] in 19 there was either a marked diminution or an entire absence of free acid.

In the absence of free HCl we may find lactic acid. They are never present together as the smallest amount of free HCl prevents the formation of the latter. Associated with lactic acid is the Oppler-Boas bacillus, the growth of which is promoted by the blood from the site of the disease. Lack of hydrochloric acid and the presence of lactic acid are not specific for cancer, but if with the lack of hydrochloric and good motor functioning, no occult blood can be detected in the stomach content or feces on repeated examination, this is presumptive evidence against the probability of cancer in doubtful cases.[13]

By means of flouroscopic examinations of the stomach after the ingestion of bismuth, the size, position and contour of the stomach can be observed.

Because of the tendency of chronic gastric ulcer to undergo carcinomatous degeneration and also because of the established fact that surgery offers the only hope for a cure of chronic gastric ulcer itself, operative measures should be undertaken early for the cure of both and for the prevention of carcinomatous change in ulcer.

In doubtful cases when the patient, of cancer age or even younger, has symptoms of chronic dyspepsia, steady loss of weight, together with evidence of lack of motility of the stomach and a condtion of dilatation, one should resort to exploratory laparotomy in order to definitely ascertain the condition existing. The mortality from this procedure is so small that it can scarcely be considered in view of the knowledge to be derived from it, in guiding the surgeon to such further operative measures as may be indicated. Moynihan[14] advises surgical treatment in all cases of stomach disorder in which there is obstruction, stasis or tumor, and in all cases of chronic ulcer. In this way early cases of carcinoma will be found and radical treatment will be possible. In the larger proportion of cases this step is deferred too long.

F. Goldschwend,[15] of Linz, states that in all cases of carcinoma of the stomach when the classical symptoms of tumor, cachexia, and coffee-ground vomit are present, the case is already inoperable, and also those cases, often prove to be inoperable, which, after a careful examination as to its size, motility, contents, etc., without palpable tumor, cachexia, or occult hemorrhage, are diagnosed carcinoma.

In spite of all efforts at early diagnosis we have not progressed very far. Every experienced diagnostician is compelled to admit that in many cases the diagnosis of beginning carcinoma the stomach must be guessed at before operation and not a few of them after the exploratory incision has been made. Osler[16] says that for a surgeon to be successful in stomach work he must be a good pathologist and able to dis-

tinguish between ulcer and carcinoma when the abdomen is opened, and even able to make a shrewd guess at ulcus carcinomatosus in its incipiency. He must be a deft and rapid operator with good technique.

The character of the operation to be performed will depend upon the condition when the abdomen has been opened.

If a chronic ulcer is found the surgeon must decide whether to excise it, to infold it, or to provide only for better drainage and a freer outlet for the stomach by a gastro-jejunostomy and leave the rest to nature. Because of the great tendency to malignancy all chronic ulcers of this organ should be removed either by local excision or gastrectomy

If a malignant growth is found a radical operation should be done if the tumor is not too extensive. Carcinomas which have caused symptoms for a considerable time before operation often give better permanent results than those which necessitate operation early, the latter generally belong to the very malignant, rapidly growing cancers. A pylorectomy or a resection of the stomach should be made after the Mayo method, and gastro-enterostomy should be done.

If the carcinoma is too far advanced for a radical operation and if it interferes with the emptying of the organ a posterior gastro-jejunostomy should be performed for the purpose of providing an outlet for the stomach and to render the patient's declining days more comfortable. Janssen[17] quoting Stumpf, advises resection even as a palliative operation, as the results are better with this than from gastro-enterostomy alone, and the mortality of 9.5 per cent is so low that it should turn the scale against it.

Lund[18], of Boston, corroborates the statement of Mayo that cancer of the stomach is as amenable to treatment as is cancer of the breast, and states that in operable cases, which means those cases in which the growth with a fair margin of stomach and the involved glands can be removed, the only treatment which gives any promise of relief is excision.

To the early diagnosis of incipient cancer of the stomach and to the recognized duty of the surgeon to prevent its growth in many cases by removing its selective location in a chronic ulcer will be due the lessening of the mortality of that almost hopeless disease. The surgical statistics in the next decennial period will show as favorably for cancer of the stomach as for this disease in other parts of the body.

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When draining a deep-seated abscess found with an aspirator, do not remove the aspirating needle until the abscess has been freely opened. (It is allowable to replace the needle by a grooved director.)—Amer. Jour. of Surg.

**Officers of Italian Society.**—The officers of the Italian Medical Society, recently organized in New York City, are as follows: President, Dr. Antonio Stella; secretary, Dr. Rocco Bellantoni; treasurer, Dr. Antonio Vernaglia; members of executive committee, Drs. Frank G. Samarelli, Joseph Grana, Louis Criscuoli and Guiseppe Di Santi, and members of the committee on audit, Drs. R. Muoio and Nicola Morano.

**A Further Contribution to Our Knowledge of Intestinal Dyspepsia.**—Max Einhorn, of New York, divides intestinal disturbances into two great classes—digestive disturbances affecting digestion of all three classes of foods and those affecting only one form of foods. He generally finds the forms to be mixed. He gives a number of case histories illustrative of both kinds of difficulty. He believes that the bead test is valuable in both. In disturbed starch digestion the clinical symptoms are slight; they consist of flatulence, fullness of the abdomen, frequent eructations, and expulsion of wind. In meat indigestion we have nausea, bad taste in the mouth, much suffering, and malodorant flatus. With disturbed fat digestion there are intense pain, soft light-colored stools, and no subjective symptoms. In universal intestinal dyspepsia there is debility, loss of appetite, diarrhea, and abdominal pain. He advocates lessening of the class of foods that is not digested, giving of drugs to aid digestion, and general hygienic, therapeutic, and climatic measures.—Med. Rec.

## SELECTED ARTICLE

### THE AUTOCRACY OF THE TRAINED NURSE—AN ARRAIGNMENT OF THE SYSTEM OF TRAINING IN VOGUE, WITH SUGGESTIONS.*

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PHILADELPHIA,

Of the University of Pennsylvania.

"I have no use for a trained nurse and would not have one of her kind in my house." Thus emphatically did a prominent lawyer in one of our great cities, President of the Board of Trustees of a large hospital express himself to me recently.

Were it generally recognized, he but voiced a very common sentiment which has been growing at an alarming rate, and is already largely prevalent among the better classes of our people. It is with extreme reluctance that I am forced to this admission. Foolishly closing one's eyes to an unpleasant fact, however, will not benefit the matter in the least. The naked truth, sooner or later, must be met, the causes for its existence ascertained, and the remedy applied if one be found. Admitting the fact, as we must, therefore, what is the cause of this remarkable reaction in popular sentiment toward a calling which should command only the profoundest respect and heartiest sympathy of everyone?

There is but one explanation, and it is to be found in the attitude, of the trained nurse herself. In making this statement I wish it to be clearly understood that I refer to the trained nurse as a class, and not to her individually, for I well know there are many noble and excellent women engaged in this humane vocation who are radically and practically opposed to the autocratic bearing of those fellow-women who are bringing down upon themselves and their calling the righteous indignation and resentment of a long-suffering people.

The attitude to which I refer, and which I shall presently elaborate, is intolerable in its every aspect. It can be traced largely, if not altogether, to one chief source, namely, the malevolent influence very commonly exerted by the imported head-nurse upon the probationers and older girls in the training-schools. I recognize that this is a startling statement, but I am speaking with a knowledge of things as they are, and I am prompted to do so with but one object in view—the befriending of the nursing fraternity. The welfare of this noble and very necessary calling is being jeopardized by defects in the course of training that can be, and must be, promptly righted if the growth of the popular antagonism to the trained nurse would be arrested. Therefore, the mincing of matters will not do. I believe the time is ripe for a bold, plain statement of facts.

#### THE IMPORTED HEAD-NURSE.

It stands to reason that those who are, and have been, in control of the training-schools for nurses throughout the country from the time of their establishment, must be responsible for the development of the system in vogue, its defects as well as its commendable features. This is a logical and necessary conclusion. It is also a well-known fact that almost without exception in the larger institutions, these dominant individuals have been foreign-born and foreign-bred women, who have even, in certain instances, so cleverly manipulated the governing factors of the hospitals in question, as to include under their supremacy the superintendentship of the entire institution—an impossible state of affairs, let me add, so far as an independent and self-respecting medical staff is concerned. Now, what has been the outcome? The net result of the system of training evolved by these women after three decades or more of absolute control is appalling. The type of nurse as depicted in the beautiful characters of Florence Nightingale and Dorothea Dix no more exists, save in rare and isolated instances, than does today the noble red man of Cooper's fascinating tales. In her place we find ourselves confronted by a cold-blooded, autocratic fraternity or close corporation, smothered in red-tapeism that apparently would sacrifice a life rather than break some inflexible and arbitrary petty law, whose main object appears to be commercialism, and from which it would seem that almost every sentiment of humanity had been obliterated. This organization is dominated and completely overshadowed by a few forceful spirits, for the most part imported from other lands, women of undoubted and unusual executive and organizing ability, who, it would seem, have thoroughly subdued and cowed the vast majority of the girls trained under the system they have devised. In no other way can be found an adequate explanation for the remarkable submission displayed by these girls under injustices that stir to the very utmost the spirits of those who acquire even a faint insight into the matter.

If you will, inquire of any observant phy-

*An address delivered before a mass meeting called at Philadelphia, Feb. 17, 1909, to review the present system of training nurses; to consider the duties, obligations and limitations of nurses in the sick room, etc.

sician who has been associated with these training-schools in whatever capacity, and he will, if sincere, assure you that the imported head-nurse has usurped an authority that is more absolute in proportion than that assumed by the Autocrat of all the Russias. She domineers over the girls in training in a manner such as a similar number of young men would not countenance for a moment. (One illustration will answer. The daughter of a leading physician of a city of central Pennsylvania when slightly indisposed one morning, was peremptorily ordered by her foreign chief to eat her "porridge" or leave the table—a command which she was woman enough to disregard until she had taken her coffee.) She reserves to herself the right to allot to the matriculates separate and distinct careers according to her personal whims and fancies, and likes and dislikes, whereby some favored ones profit by an excess, and others under the ban of official disfavor suffer from a deficiency, in the practical courses afforded by the schools. She arbitrarily curtails or prolongs the course in training to suit her personal plans or to regulate the excess or deficiency in the number of matriculates, without respect or consideration for the rights or convenience of the individual girls; and she caps her authority by claiming the privilege of refusing a diploma after a long and tyrannous course of training, to any or every nurse who in any manner, trifling or otherwise, may have incurred her displeasure. Her despotism is absolute; there is no court of appeal. It matters not that three years or more have been consumed in arduous, earnest toil. It matters not that the pressure of poverty is threatening, or that the girl may be looking forward eagerly to the time when she may bring her hard-wrought earnings to the support of her family. One dereliction of duty or one breach of an arbitrary hospital rule will annul all that has gone before, and the offending girl may be, and frequently is, summarily dismissed from the institution in disgrace. Is it to be wondered at that the number of native girls, imbued with the spirit of American independence and superlative womanhood, seeking admission to these training-schools has diminished remarkably in recent years, or that the average standard of mentality and moral tone of those who do matriculate is not all that the friends of scientific nursing would desire? Is it any wonder that those who weather the storm of tryannous abuse and win the coveted piece of parchment or official document suffer the inevitable reaction that such injustice engenders? Who can blame them altogether for fostering a feeling of retaliation which they can inflict only upon an inoffensive and supine public? Herein do we find the true explanation for the autocratic and offensive stand taken by a certain element of the nursing fraternity, and to this ultimate cause can all the disastrous and distressing train of evils be irrefutably traced.

"MENE MENE, TEKEL, UPHARSIN."

What is the conclusion to which we are irresistibly driven? This only: The extant system of training to our schools of nursing has been weighed in the balances of time and results, and in many of its features has been found wanting. The final outcome of the mal-administration and mistraining of those who are in authority is an evil which threatens not only the flimsy superstructure they have erected but even the very foundations of the nursing fraternity as well. What are the results that obtain? Subjected to an ultimate analysis they appear as follows:

A lower standard of mentality and morality among the matriculates and graduates;

The almost total obliteration of the humanitarian aspect of the vocation;

A notable diminution in the number of applications for matriculation from the native American girls;

A remarkable and suggestive increase in the number of matriculates from other countries;

An irregularity in the individual course of training which is strongly suggestive of a medieval and irresponsible autocracy;

A commercialism among the graduate nurses which is more suggestive of class discrimination than is the most radical trade-unionism;

A growing popular antagonism to a calling which should be held in the highest esteem by the people of all classes.

As far as the imported head-nurse personally is concerned, there are two main causes, as I see it, for the deplorable failure she has achieved, and probably the foremost and that of prime importance is the lack of affiliation between her and the students. Without exception, in my experience, she has not won the confidence and affectionate regard of the student classes. On the contrary, she is heartily disliked by all and abjectly feared by many. This, in and of itself, is a fatal error. Why this should be is beyond my province to state positively, but from my chance personal observations I should attribute it largely to the despotic administration which she

has seen proper to institute and which I have already referred to.

Again, it is unfortunately true that these women, earnest though they may be in their love for their chosen calling, are very often weak enough to permit national ties to influence and even to master them. They seem to forget that they are aliens, mere sojourners in a strange land, with ostensibly but one object in view, and that the training of the native girls in their own adopted calling. Hence it comes to pass that in most of these training-schools the Canadian girls and those coming from across the sea are favored in every possible manner. I am told by one who is thoroughly acquainted with the intricacies of the problem, that in one of the schools in a neighboring state, from 85 to 90 per cent of the girls are of Canadian extraction. A physician of my own city who is connected with one of the prominent hospitals, recently informed me that the foreign head-nurse and superintendent of the institution astounded him by remarking: "Your American girls are uterly incapable as trained nurses. When I want a really good nurse I must send to Canada for her!" Such a statement, which, it is needless to say, is altogether without foundation in fact, and as absurd as it is false, is an affront to American womanhood, and could be prompted only by a partizan feeling of nationality, which at once stamped the speaker as entirely unfit to fill the position she held. Be this as it may, the woman but typified her class, which almost without exception, is strongly influenced by national prejudice.

### ERRORS IN THE SYSTEM OF TRAINING.

In addition to these personal traits of the superintendents of nursing, which have done much to bring to pass the present unfortunate state of affairs, it stands to reason that mistakes should be made in the process of constructing a new system of nursing founded on modern scientific principles. Time alone can determine the value or uselessness of anything, and of a system or theory as well. That which promises well at the outset may result disastrously in the long run. Therefore, there are to be found in the system of training, as now advocated, certain glaring faults demanding immediate correction or elimination in order that a degree of perfection may be attained.

In a recent address delivered before the graduating class of the Philadelphia School for Nurses I took occasion to call attention to some of these evils.

It is my desire at this time to enlarge upon these defects, and to point out, as far as this may be possible and practicable, the remedy—which, let me emphaisze, must be radical in order to eliminate the canker which is marring and even threatening to destroy one of the noblest aspects of Samaritanism in the world.

### THE EDUCATION OF A NURSE.

In the first place, then, the education of a nurse does not mean a comprehensive instruction in the arts of scrubbing, washing and the other ordinary kitchen duties. Yet how often do we see from five to ten months or more consumed in just such menial labor as this? Frequently has my indignation burned when I have seen sweet and refined young girls who came from homes of culture and dignity compelled to perform tasks which they had never dreamt of when at home, which they would never be called upon to do after their graduation and which would bear no more relationship to their education as trained nurses than would a knowledge of horse-shoeing or of cobbling. And somehow I never could quite free myself from a lurking suspicion that there was an economic reason behind it all, and this suspicion was largely confirmed when I noticed the conspicuous lack of hired help in such institutions.

Of course, this extra and altogether useless work, so far as concerns the actual training of a nurse, consumes time which can only be taken at the expense of the matriculates, and ultimately and indirectly of the patients. The course of training is thereby unnecessarily lengthened by at least one year. And to what purpose? None whatever, save a curtailment in the running expenses of the institution which will make a somewhat favorable showing at the expiration of the fiscal year. Can this in any sense be construed to represent a square deal? Just as appropriate, it seems to me, would it be to add to a course in medical training an extra year in which the students would be compelled to clean and polish medical and surgical instruments and other paraphernalia, and then claim that thereby the preparation of the students for the practice of their profession is the better and more thorough. And just as consistent would it be to condemn as inferior and mediocre all other colleges which did not countenance this imposition upon their student bodies and proclaim these institutions as affording courses of instruction of a lower standard than that set by them. I enter a hearty protest against this injustice to our student nurses, who

have entered a training-school, as they believed, and have not matriculated in an employment agency.

Again, it is not necessary that a nurse should acquire an extensive medical education equal to at least a two-years' course in a medical college. She is not to become a poor doctor, but the best of nurses, and rest assured there is a vast distinction between the two.

This, I believe, may be regarded as axiomatic—that good nursing is not facilitated by too elaborate an education in professonal matters; rather is it hampered or even rendered useless thereby. A superficial knowledge of physiology and anatomy, together with a thorough acquaintance with hygiene, will answer every purpose. It is just as well that the nurse should know that the femur has nothing to do with the arm, but it is beyond her province to expect her to accurately set a broken limb. Every nurse should know that there are certain disease-bearing or disease-producing germs, and that these may be, and generally are, carried by means of unclean hands or instruments; but, as I see it, it is not essential for her to trace the life-history of a bacillus, nor to enumerate the pyogenic germs, nor will it aid her nursing in the slightest degree to know that the Bacillus bremensis febris gastrica will produce symptoms closely resembling typhoid fever, but in which the Widal reaction cannot be obtained. A fair knowledge of pharmacy, however, together with the ability to quickly and accurately make percentage solutions, is an excellent adjuvant to the ability to record a temperature, a pulse-rate and a pulse-respiration ratio. If, in addition, a course of instruction in nursing is engrafted upon a fair general education, and this is backed up by a heap of common sense, then may we expect to find a capable nurse—provided she has the nursing instinct. For, let it be borne in mind that not every girl is cut out to be a nurse any more than is every man constituted physically or mentally to be a physician. A good nurse is born, not made.

Some one has defined the functions of a nurse as follows: "To care for the bodily needs of the patient; to carry out the physicians' orders; to keep a careful record of the happenings of the sick-room as regards the vital phenomena of the patient. Everything that the nurse needs to do or know may be grouped under one of these three functions, and any teaching that contemplates anything beyond this would merely burden the nurse with useless theory or inspire her with the erroneous and fatal idea that she is endowed with the knowledge and skill of the medical attendant." Is it necessary for any woman blessed with the average gifts of brain and common sense to spend three or four years in acquiring a nurse's diploma when this is all that will be expected or required of her? Why, then, is this asked of her, and an intricate and altogether useless curriculum imposed upon her, and often at the expiration of this long and tedious course a diploma denied her because of some breach of a petty hospital regulation arbitrarily laid down? I fear me there is an economic reason attached to this, as well, and I enter a protest against such unfair dealing as this on the part of institutions against young girls who come to them in all good faith to acquire instruction in their chosen vocation. I do not think it is a square deal.

### THE TRAINING OF A NURSE.

The training of a nurse is quite a different matter. A nurse may be over-educated; she can never be over-trained. Just as absurd would it be to state that a surgeon is over-skilled or a physician over-expert in his methods of diagnosis. The more training and experience a nurse can acquire, the better for her and for her patients; and is the prolonged hospital courses that are required of her in so many of our training-schools consisted mainly in bedside, ward and out-patient instruction, I should be the last man in the world to breathe a word of remonstrance—save this: She might have speedier financial returns were her instruction-period not so unnecessarily protracted.

Even in this question of the training of a nurse there is a grievance which is most pernicious in its effects upon the morale of the matriculates. I refer to their irregularity in the course of trainng. Not so much do I mean the irregularity in the curriculum of one training-school as compared with that of another, although I believe that there should be a general system adopted, as far as that may be practicable, even as there is in the various medical colleges. Rather do I refer to the flagrant irregularities in the individual course, whereby one favorite nurse profits by an excess of bedside or out-patient instruction, and another draws in the lottery of favoritism a special career as clinic nurse, while a third bears the brunt of official disfavor and rounds out her career as hospital drudge. Nepotism or favoritism in any of its aspects is most pernicious. Any girl matriculating in a training-school should enter with the assurance that she is to profit in every respect according to the facilities

afforded by the given institution. Religious creed, nationality and the personal equation bear no relationship whatever to the course of instruction. An impartial administration must be expected; and let me emphatically state here that this impartiality can be demanded and insisted upon by a proper and respectful co-operation on the part of the student body. It is its just right, and the favoring of one student in any respect should be regarded as a dangerous precedent, and should not be tolerated by the student body itself nor by the board of directors of the instituiton.

### THE RESULT OF THE SYSTEM.

The ultimate result of such a course of mis-training as that which is here depicted is the objectionable attitude assumed by the average graduate nurse, reference to which has been made in the opening paragraphs of this paper. This attitude is characterized (1) by an offensive and autocratic bearing in the home which is detrimental to the peace and welfare of the family, and which emanates entirely from a mistaken exalted idea of the importance of her calling; (2) frequently by an illy-concealed antagonism to the attending physician with a tendency to neglect or openly to oppose and counteract his instructions; (3) by a notable and lamentable disregard of the high standard of ethics which has ever dominated the medical profession in all lands and ages; and (4) by an open bent toward commercialism which is fundamentally and radically opposed to the humanitarian motive which, as is generally understood, prompted the founding of the nursing fraternity.

Because of this unpleasant attitude has sprung up the sentiment of popular disfavor which is being openly expressed more and more emphatically against the intrusion into the home and family circle of the modern trained nurse. It is with the earnest desire to offset this trend of the popular mind, and to arrive, if possible, at a satisfactory solution of the question, that this paper has been prepared.

Now, let me ask in all good faith, have I not proved the friendliness of my attitude toward the trained nurse? I am her friend, in very truth. I sympathize with her from the bottom of my heart. Her life is a hard one, beset with physical perils. Is it any wonder, when we come to consider her prolonged immurement in the sick-room, the constant inhalation of germs and their noxious, putrefactive products, the loss of sleep and the irregularities in her diet—is it any wonder, I repeat, that she so frequently succumbs to disease or finds it necessary to seek retirement for protracted periods to recuperate her shattered nerves?

It is, then, because I am the friend of the nurse that I feel actual regret when I see her yielding to temptations that imperil her high calling. It is because I am her friend that I feel prompted to remonstrate, in a kindly way, with her, when I see her tottering over pitfalls that can work her only injury and injustice. And so, when I come to speak to her of some of these faults on her part, I do so not uncharitably, but with a real interest in her welfare, and with a desire to render her some assistance over the hard places in her career.

### THE GROWTH OF A NURSE.

The growth of a nurse, therefore, is the very necessary and logical subject to which I would now direct your attention. A nurse has acquired her diploma, and is entitled to offer her services to afflicted humanity. What does she often do? Alas! If you look opposite her name in the Nurses' Directory in which she is registered, you find the startling legend, "For twenty or twenty-five dollar cases only!" With one stroke she annihilates the years of experience that one would deem essential, and leaps at once into the seats of the mighty in her profession. It matters not that her wiser sister has been devoting her energies to her calling for five or ten years, and now claims her right as a twenty-five-dollar nurse. Has she not a diploma? Therefore it is her privilege to demand the highest remuneration her profession affords. So she argues. How many young doctors, think you, can claim five or ten dollars per visit the first few years of their professional careers? How many surgeons can place the bold-typed card upon their mantel-pieces, "$500 cases only?" I believe the nurse earns all she can get, and even then is not well paid. But hers is also a humane calling, and when she stamps it with a mercenary mark, then she drags it from its high pedestal and wrongs herself and it. I know many physicians who have expressed themselves as unwilling to recommend a nurse who registers herself in this manner. "If she will not take the fifteen-dollar case," they say, "she shall not have the twenty-five-dollar case." Honestly, I think they are right.

The growth of a nurse is naturally, and should be recognized as a process of evolution. If there is not this improvement, this evolution, with the lapse of time, then is there something radically wrong. Therefore, I enter a protest—in the kindliest spirit, I assure you—against the autocracy

of those trained nurses whose spirit is hard and mercenary and whose slogan is "do the public—good."

Lest there be some who think I am mistaken in this matter, permit me to quote the schedule of prices advocated by these mistaken enthusiasts, and printed in an organ of the nursing fraternity (American Journal of Nursing, Vol. III, No. 2, page 886): "Acute diseases, $25 per week; maternity cases, $30 for the first week, $25 for succeeding weeks, unless there are two nurses, when $25 per week each, will be charged for the entire time; nervous cases, $30 per week; contagious cases, $30 per week; for attendance at an operation, or one day's engagement, $5; from two to six days, $4 per day." Then, with a grim sense of humor worthy of a Carlyle or a Swift, as a special concession the very generous statement is affixed: "No extra charge is to be made for attending to the body after death."

I appeal to my hearers. What could be more cold-blooded and revolting than this? As some one has written, "Arguments may be brought forward to justify trades-unions in the commercial world, but the most case-hardened and reckless agitator and striker would shrink from trading in the blood and sufferings of humanity." If the same principle should be adopted by the medical profession and invariably lived up to, the poor and middle classes would be entirely deprived of medical attendance, save that afforded by hospitals and eleemosynary institutions. No greater instance of class distinction—against which socialism and the unions are raising their earnest protests—could be imagined. Therefore, I beg of my hearers, in the name and for the sake of humanity, to concentrate their influence against such commercialism as this.

### STATE REGISTRATION OF NURSES.

There is one other matter on which I desire to speak a few words in closing. I refer to the recent agitation in a number of the States on the question of the registration of nurses. Let me say at the out-start that I do not think the time is ripe for such a movement on the part of the nursing fraternity. However it may eventuate, today the finger of public opinion points unequivocally away from such a procedure as this. Sound the views of the level-headed in the community, if you will, and you will find, if I mistake not, a strong feeling permeating all the social strata antagonistic to anything which savors of trade-unionism among the learned professions, including the nursing fraternity, and this movement for registration is deeply dyed with such a taint.

It will be of general interest to note that the idea of State registration is not indigenous here but is purly exotic, having taken its origin among the women sojournng in this country from the British Isles, where, by the way, I notice it has also stirred up a violent storm of protest. It is also well worth noting that its most ardent advocates in this country are the imported head-nurses—a fact which, in and of itself, in the light of all the disastrous results to which I have here called attention, should at least lead to a cautious inquiry into the matter, and entail a slowness and deliberation of action. It is, probably, the strongest weapon these women can bring into play in order to perpetuate their hold upon the nursing fraternity in this country. Personally, I do not hesitate to declare myself as emphatically opposed to the movement, and I can safely add that the medical profession as a whole is opposed to State registration of nurses in any form. The feeling, however, is not confined to the medical men by any means.

The Honorable William N. Ashman, President Judge of the Orphans' Court of the city of Philadelphia, while speaking on this subject, said: "It has been urged by some of the friends of the proposed law" (the State law for licensing and registering nurses) "that to meet the demand of people of moderate income for skilled nursing will lower the rate of compensation, since the average citizen and the poor have not deep purses. This seems to indicate that the real reason for appealing to the Legislature is not a question of the welfare of humanity, but a matter of dollars and cents. The public good cannot be held in abeyance for the sake of private gain. Civilization has advanced too far to admit of the capitalization of the sufferings of humanity. The interests of the sick man were safeguarded when the State licensed and appointed the physician as the absolute authority in the sick-room. When two generals with equal authority attempt to manipulate the same army, the battle is generally lost." Such is the opinion of an eminent jurist of the land.

The distinguished professor of medicine in Cornell University, Dr. W. Gilman Thompson, for whom I entertain the profoundest respect and admiration, has recently said (New York Medical Journal, April 28th, 1906): "We are in the hands today in this State (the State of New York) of a nurses' trust. There is no more real need of State examination and registration of

nurses than for the examination and registration of a group of persons employed in any one of the liberal arts." He then proceeds to add, as a further protest against the injustice of the whole matter that the "unfortunate patient is compelled to pay the same rate for the poorest nurse that is demanded for the best, and that patients of moderate means must pay the high price for a nurse or do without." A physician of my own city recently asked one of these women who was heartily advocating this stand on the part of the nurses, what the people should do who were unable to pay such a price and received the stern reply: "Let them do without!"

It will not be necessary for me to quote further from the views of men of distinction in their chosen professions. I have read the criticisms of many of the medical men of my own State upon the proposed act. They all sounded no uncertain note. Many of them were most amusing, and some were more positive than polite. As I have intimated throughout this paper, I am heartily in favor of fair play for every one, including the nurse. I believe, therefore, that such an act as that which has been contemplated in various States of the Union authorizing the State registration of nurses is unfair to everyone, including the nurse; that it is unwise at the present time and in view of the recognized trend of public opinion; that it is contrary to the humane spirit which is supposed to actuate those engaged in alleviating the sufferings of mankind, and that it is uncalled for from whatever point of view it may be regarded. Thus do I publicly place myself on record, and I appeal to the public to give the matter careful and judicious consideration before permitting an endorsement of a movement that might readily work a lasting injury to the noble vocation of the trained nurse.

### THE REMEDY.

Such is the pernicious system of training for nurses in vogue in this country, these are its originators and supporters, and these the results of three decades of trial. What now, is the remedy? Far be it from me to do it otherwise than to offer a few suggestions as follows:

First and foremost. The abolition of the imported head-nurse, and the substitution in her place of native women trained at home and free from the undesirable traits of the prevailing system.

Secondly. A curtailment of the course of training so that it shall not in any instance exceed two years. Already, I understand, has such a step been taken in Chicago and elsewhere.

Thirdly. The elimination from the course of all unnecessary medical, surgical and other instruction which does not pertain to the proper education of a nurse, and which has apparently been incorporated with the obvious purpose in view of unduly prolonging the course in order to hold the services of the matriculates, or to enhance in their minds the importance of their chosen calling. Moreover, it stands to reason that the elected courses of instruction should be given by teachers of large practical experience and not by immature young medical graduates.

Fourthly. The just regulation of the course of training so that each and every matriculate shall be assured of a systematic equalization of the hours of instruction in the various branches.

Fifthly. The shortening of the daily periods of service for the individual nurses so that these shall not exceed six hours at a stretch, and the insistence upon a regular rotation of service for the girls. This will correct the obvious evil of a continuous service of from twelve to eighteen hours, as is frequently insisted upon at present, and often to the lasting injury of the nurse or patient, or both.

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To develop manual dexterity nothing is better than the practice of tying surgical knots.—Amer. Jour. of Surg.

**No Over-crowded Medical Profession in China.**—The province of Shansi, China, with a population of over 12,000,000, offers an inviting field to the Christian physician. Dr. W. A. Hemingway, a medical missionary of the American Board, has a small hospital at Tai-ku, where he treated 2177 cases last year, besides a large number of dispensary patients. He is not troubled with rivals, the nearest hospital on the north being 35 miles distant, on the east and south 150 miles, while on the west there is none nearer than Persia. With only two Chinese assistants and two native men nurses Dr. Hemingway has accomplished wonders since he went out in 1903. Shansi men are famous all over China for their business ability, especially as bankers. But the entire province, once wealthy, is cursed with the opium habit and many of the victims come to this hospital for treatment. The price of the drug has doubled lately, thus forcing the poor to abandon its use, and the law is rigidly enforced that the poppy shall not be planted, nor opium brought into the province from outside.

# THE MEDICAL FORTNIGHTLY

**Issued Tenth and Twenty-Fifth of Every Month**
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## EDITORIAL

**The M. V. M. A. Meeting.**

In another department we are publishing the preliminary program of the meeting of the Mississippi Valley Medical Association for the meeting which is to be held in this city October 12, 13 and 14 next, it bears out our statement in our last issue that this is to be a scientific feast. But something more is being prepared than appears in the published program: The Surgeon-General of the Marine Hospital Service has detailed Dr. C. H. Lavinder, assistant surgeon, to read a paper on "Pellagra," and Dr. C. W. Stiles, of Washington, another, which will be illustrated by stereopticon slides, on "Hookworm Disease." Dr. B. S. Warren, of the U. S. Marine Hospital at St. Louis, has also been detailed to take part in the proceedings and will open the discussion of the paper of Major S. C. Stanton on "Camp Sanitation." Dr. Lavinder is the highest American authority on pellagra, and Dr. Stiles occupies a similar position relative to hookworm disease. Efforts are being made to have brought her for the meeting several patients from Peoria who are under treatment for pellagra, and indications are that this clinic will do much to acquaint the profession with this, to us, new disease.

It is not bad advice to suggest to members that hotel accommodation should be secured in advance; St. Louis hotels are busy, and it is quite possible that you may not be able to secure what you most desire if you make no reservation in advance. All the work of the association is to be done in the Southern, and there are naturally many advantages in being located in that hotel; the only way to be certain of quarters there is through definite advance reservation. Excursion rates over roads entering St. Louis are available for the meeting on the certificate plan; certificates should be secured when purchasing tickets. The remarkably low rate offered in connection with the St. Louis Centennial, which is to be celebrated October 3-9, will doubtless tempt many members to come for the two weeks; it has not yet been possible to determine whether or not excursion rates can be made to cover the longer period.

The editor of the Fortnightly will gladly make hotel reservations or otherwise serve members who desire it.

**The Diagnosis of Ureteral Tuberculosis.**

Tuberculosis of the urinary tract has been receiving a considerable amount of attention from the profession during recent months, but no more than it deserves. Even now there are not a few who are not entirely settled in their minds as to whether the disease is always a descending or sometimes an ascending trouble. While the kidney and the bladder have been carefully studied and voluminous notes recorded there has not been so much said of the invasion of the tissue of the ureter itself, for this reason we have read with not a little interest and benefit an article by Bryon Robinson on the Diagnosis of Ureteral Tuberculosis,* in which he holds that ureteral tuberculosis is inseparably connected with renal tuberculosis. Hence both must be studied in conjunction for the final accomplishments of medicine and surgery. Statistics would appear to demonstrate that tubercular ureteritis is, in the beginning, chiefly unilateral—in 70 per cent. Acute infection of the kidney is bilateral, but since ureteral and renal tuberculosis is due to lymphatic channels, it originates mainly unilateral. Reno-ureteral phthisis is not the most fatal form of tuberculosis. Kornfield demonstrated that reno-ureteral tuberculosis proved remarkably benign in 104 subjects. It may be assumed that at one or more periods of life 50 per cent are tubercular. More tubercular patients recover than die. The diagnostic tests, each of which the author discusses at length are: 1, Inspection; 2, percussion; 3, palpation; 4, pain; 5, tubercle bacillus; 6, cystoscope; 7, ureteral catheterization; 8, functional capacity of each kidney (ureter); 9, phloridzin test; 10, methylene blue test; 11, tuberculin test; 12, X-ray test; 13, cryoscopy test; 14, urea (nitrogen); 15, chloride test; 16, albumen test.

In the diagnosis of ureteral tuberculosis

*Indianapolis Medical Journal, July, 1909.

many problems remain unsettled, viz: The presence of the tubercle bacillus in the urine may be due to filtration through the intact kidney (hence does not indicate operation); the unsatisfactory results of nephrectomy; renal functional tests are not infallible; any test may fail to locate a tubercular collection which does not eliminate its bacilli into the urinal stream through the calyces (or cribrum benedictum); renal tuberculosis is secondary process to general corporeal tubercular foci (especially in peribronchial glands epididymus); the reno-ureteral focus frequently bilateral. In recent articles a few writers have rejected many of the urologic tests, such as phloridzin, cryoscopy and methylene blue, but the author, from experience, has found the cystoscope, ureteral catheterization, the X-ray and urinalysis of invaluable diagnostic aid in urology.

**The Autocracy of the Trained Nurse.**

The medical profession in Missouri recently lent its assistance to secure the enactment of a State law for the registration of trained nurses, in so far as we know there was never any opposition to the law on the part of our profession, and we have heard, in the profession, only regret expressed that the law as enacted did not make registration obligatory instead of optional. That there is a "trained nurse problem" we all know. That the trained nurse employs trades union methods in the matter of hours of service and pay therefor is also well known, these are methods which are out of harmony with a calling which aims to be classed with the "learned professions," even did the training of nurses fit them to be so classed, which it does not. In another department we are reproducing an article by Dr. W. A. Newman Dorland of the University of Pennsylvania, which was delivered before a mass meeting of physicians, jurists, clergymen, and other prominent citizens of Philadelphia, the meeting being the result of an effort by nurses to gain legal recognition in Pennsylvania along the lines laid down for the learned professions, and as a result of the methods of training nurses in training schools, and as a result of the assumption by nurses themselves of an authority with the patient, his family and toward the medical profession which her training never contemplated and her duties never can excuse. The character and position of the speakers and audience at this meeting establishes the subject as one demanding seriously thoughtful consideration. The meeting adopted the following resolutions:

"1. That it is not necessary or desirable that nurses shall be instructed in subjects that relate almost wholly to the practice of medicine.

"2. That the tendency of some nurses to assume that they are justified in interfering with the treatment or dictating to the attending physician is to be condemned, aud any teaching which favors such assnmption is fundamentally wrong.

"3. That nurses are not competent either by education or experience to be considered as consultants, or as having equality of privilege and duty in directing the affairs of the sick-room, and any sort of legalized incompetence is dangerous.

"4. That trade-unionism in nursing cannot be justified from any standpoint whatsoever, since the families of the laboring classes, and people of moderate income and the poor, would be the first to suffer; and the fixing of $25 per week as a minimum charge would be equivalent to saying that only the rich are entitled to nursing care and that others less favored can suffer or die in neglect.

"5. That legislation which contemplates giving a few individuals power to dictate to great institutions; favoring a few persons and discriminating against others; permitting the use of the machinery of the State to stifle competition and denying benefits to the poor while favoring the rich, is contrary to the spirit of American liberty.

"6. That since the demand and need for nurses is constantly increasing, while the supply is at all times inadequate, any legislation which would diminish or limit the supply or tend to discredit or destroy the calling of the nurse would be a public calamity.

"7. That the State registration of nurses in any form is neither necessary nor desirable.

"8. That the interests of the patient were sufficiently safeguarded by the State when the doctor was legally recognized as the absolute authority in the sick-room having control and direction of both the treatment and the nursing, and that the introduction of any other authority would be dangerous and detrimental to every interest involved.

"9. That it is the duty of the nurse to render intelligent obedience to the instructions of the attending physician; to submit the question of recognition and compensa-

tion to the test and reward of merit and to follow the calling in a spirit of mercy and compassion.

"10. That the addresses of Mr. Gable, Dr. Dorland and Dr. Beates be printed in pamphlet form, and copies forwarded to the President and Secretary of county medical society, to the managers and medical staff of hospitals and training schools for nurses, and that at least 5,000 additional copies be printed for gratuitous distribution among physicians or other persons who may be interested.

"11. That these resolutions be printed and a copy forwarded to the secretary of every county medical society throughout the country with the request that they be read at a regular meeting of the society, and that copies also be furnished to the entire medical press.

NOTE.—Copies of the addresses can be secured by addressing Physicians' National Board of Regents, 1717 Chestnut street, Philadelphia.

## ST. LOUIS ITEMS.

**Dr. A. C. F. Brown** has opened an office at 2924 N. Taylor Avenue.

**Dr. W. J. Calvert,** formerly of this city, but for some time professor in our State University at Columbia, has severed his connection with the University to assume the chair of medicine in Baylor University Medical Department at Dallas, Texas.

**The St. Louis Medical Society** resumed its session on September 18th. The first meeting after the summer's recess was devoted to the consideration of the Municipal Tuberculosis Commission and the work which it has accomplished and purposes to accomplish in the future.

**Dr. W. W. Graves** writes from Budapest of a most delightful and extensive tour through Europe with that city as his objective point. Dr. and Mrs. Graves will attend the International Congress, and shortly after will return to America and St. Louis. Several St. Louis physicians are at Budapest for the Congress.

**Dr. A. H. Hamel,** president of the Missouri State Board of Health, is, at the suggestion of Governor Hadley, taking steps which purpose a more sanitary condition of railway cars within the borders of the State. Report has it that the managers of the various lines take kindly to the suggestion and lend their assistance to its successful carrying out.

**Dr. Chas. Shattinger** has lately returned from an extended western vacation trip, the greater part of his absence was spent in Washington and the Canadian Northwest.

**St. Louis is Making** extensive preparations for the centennial celebration, which is to be observed from October 3 to 9. The repaving and cleansing of down-town streets and the erection of lamps for one of the most elaborate of street illuminations ever undertaken by any city is now well under way. Parades, balloon and other races, concerts, balls and other festivities will fill the week. Remarkably low rates are offered by all railroads.

**Too Many Strings to the Gift.**—Fifty thousand dollars donated by Mrs. Sophronia A. Harrington, of Winchester, Mass., for the erection of a memorial hospital in that town has been returned to the donor, as the trustees were unable to comply with the conditions on which the gift was made.

**Condensed Milk.**—During the past decade $16,000,000 worth of condensed milk has been exported from the United States, about $2,500,000 having been realized from the exportation of this product in the fiscal year 1908. In recent years the exportation of milk to foreign countries has shown rapid increase, practically all the output being shipped in condensed from, that in the natural state probably not exceeding one per cent. In 1895 the shipments amounted to $219,785; in 1898, $671,670; in 1890, $1,139,402; in 1905, $2,156,616; and in 1908, $2,455,186.

**The Opium Farmer.** — The anti-opium crusade, which has assumed world-wide proportions, is materially interfering with the opium trade in China. The growth of the poppy plant is being abandoned and, at the present rate, the time will soon come when the opium growers must look for some other means to obtain revenue from their lands. Unfortunately, most of the Chinese opium fields are located in a rough, inaccessible country where crops of grain and other usual commodities cannot be transported to railroad stations. Opium being comparatively light in proportion to its price, is carried out of this rough country with little expense. The Chinese government looks after the farmer with the same parental care that we find exercised in the United States, and it is likely that railroads will be built in the opium districts in order to accommodate farmers as they change from opium to more bulky crops.

# MEDICAL PROGRESS

Comprising the Regular Contributions of the Fortnightly Department Staff.

## INTERNAL MEDICINE.

O. E. LADEMANN, M. D.

**Clinical Diagnosis of Pulmonary Tuberculosis.**—Miller (New York Med. Jour., Aug. 14, 1909) emphasizes the following points: The attitude of every physician toward tuberculosis should be that of constant suspicion. The history of intimate exposure to infection and a detailed inquiry into previous illnesses are of the greatest importance. A properly conducted physical examination is the cornerstone of the diagnosis, but physical signs of tuberculous toxemia are quite as important as are the signs in the lungs. Prolonged and repeated examinations are often essential. Failure to find the tubercle bacilli in the sputum and other excretions is evidence of little value. The tuberculin tests are valuable in connection with the clinical manifestations, but their exact significance is not yet absolutely determined. In general, the diagnosis is based on no one sign, symptom or test, but on a careful correlation of all the evidence into a rational clinical picture.

**The Early Diagnosis of Pulmonary Tuberculosis.**—Gaines (Medical Record, Aug. 28, 1909) summarizes his paper as follows: 1. The clinical picture of every early pulmonary tuberculosis is utterly different from what is propularly known as consumption. 2. The symptoms of early tuberculosis are exceedingly insidious, and easily overlooked in a considerable number of cases. The laity particularly should be instructed concerning the nature of these early symptoms and physicians should be on the alert for them. 3. The physical signs of early tuberculosis are difficult of detection, and necessitate a particularly careful examination. 4. Tuberculin properly and carefully applied is of great value in diagnosing early afebrile cases. 5. The prolonged absence of bacilli from the sputum is of no value in diagnosis.

**The Etiology of Arthritis Deformans.**—Heckmann (Muenchener Med. Wochenschrift, Aug. 3, 1909) speaks of arthritis deformans as being either monourticular or polyarticular. He briefly details a number of cases of each type. A suggestive or definite syphilitic history was obtainable in each case together with a reaction positive to the Wassermann, Wassermann-Noguchi and globulin (Noguchi) tests. The author regards the mono-articular type of arthritis deformaus (the senile forms excluded) as an arthritis usually resulting from the immediate effects of an injury to the joint but the underlaying causes is one of constitutional syphilis. The syphilis is responsible for the fact that the contusion of the joint and the subsequent synovitis do not heal as they do in a healthy person but instead lead to a progressive arthritis deformous. In speaking of the polyarticular variety he says there are two factors responsible—a rheumatic disposition and an underlying constitutional syphilis. Polyathritis deformans, at least in a considerable percentage of cases is a chronic or subacute articular rheumatism in syphilitics. Constitutional syphilis is here likewise responsible for the rheumatic affection not healing as ordinarily, but developing into a typical form of polyathritis deformans.

**Acetone Bodies in the Urine and the Ferric Chloride Reaction.** — Stern (Archives of Diagnosis, Apr., 1909) summarizes his paper on the subject as follows: 1. A positive ferric chloride reaction is usually indicative of a state of acidosis, but the reaction is solely due to the presence of aceto-acetic acid (diatcetic acid). 2. A negative ferric chloride reactions does not preclude the presence of either oxybutyric acid or acetone. 3. The ferric chloride test should be applied to freshly voided urine only, as the entire aceto-acetic acid or a portion of it, by a loss of $CO_2$ may be converted into acetone if the urine be standing for some time. 4. As a rule, no acetone at all, or only small amounts, exists in a preformed state in the freshly voided native urine. Standing of the urine or reagents cause liberation of acetone from aceto-acetic acid. 5. The presence of aceto-acetic acid or of aceto-acetic acid and acetone does not of necessity point to the occurrence in clinical amounts of beta-oxybuytric acid. 6. Oxybutric acid not demonstrable by simple testing methods, may be readily discerned by its rancid odor. 8. A direct seach should invariably be made for acetone by one or other of the acetone tests. It must be remembered that the urine after the administration of the salicylates also gives a port wine color upon addition of ferric chloride, due to the presence of salicyluric acid. The presence of diacetic acid should be assumed only if: (1) Boiled urine is used for the test; here the red color should be much fainter. 2. The urine is acidified with sulphuric acid and shaken with ether. Diacetic acid, if present, will be taken up by the ether, and if the latter is shaken

with a solution of ferric chloride the aqueous layer will turn red. This coloring will disappear spontaneously in 24 to 48 hours. The color produced by salicylic acid, its compounds and certain other substances remains permanent for days.

**Detection of Tubercle Bacilli in the Blood by Rosenberger's Method.**—Ravenel (Wisconsin Med. Jour., July, 1909) made an examination of the blood of 18 tuberculous patients by this simple method and failed to find the tubercle bacillus in the blood of a single case. This investigation has been confirmed by reports from all over the world and the only conclusion that can be reached is that the Rosenberger method is of no value.

**The Sediment Test in the Diagnosis of Gastric Ulcer and Gastric Catarrh.**—Grandauer (Deutsche Med. Wochenschrift, No. 31, 1909) suggests a simple diagnostic procedure which he believes to be of value in the diagnosis of gastric ulcer. He gives 2 grams of the subnitrate of bismuth on an empty stomach the night preceding a test breakfast. The test meal is removed in three portions one hour after its administration. The first portion consists of the undiluted contents, the second is that which can be obtained with 100 c.c. of wash water, and the third consists of all the wash water required to thoroughly cleanse the organ. The first portion is used for the ordinary gastric analysis, the second and third portions are allowed to sediment and a few drops of the bottom are removed by means of a pipette and examined microscopically for bismuth. In normal stomachs and cases with purely neurotic gastric affections no trace of bismuth is evidenced, while in cases associated with crevices in the gastric mucosa, such as ulcer, cancer and erosions it is present in the wash water. The test is also positive in chronic gastritis due to the bismuth being held by the mucous present in the stomach. The writer therefore concludes that in the absence of motor insufficiency, cancer and gastritis the finding of bismuth in any quantity is diagnostic of ulcer.

**The Presence of Tubercle Bacilli in the Urine of Tuberculous Patients, Their Significance and Dangers.**—Beardsley (N.Y. Med. Jour., Aug. 14, 1909) contends that acid and alcohol fast bacilli are frequently present in the urine of tuberculous patients. Such bacilli have been proved in many instances to be capable of producing tuberculosis in animals. Until it is conclusively proved that these bacilli are not virulent it is wise to consider all of them virulent. It is reasonable to believe that in tuberculosis, tubercle bacilli are present at times in the blood of the individual. Tubercle bacilli may be present in the urine without a microscopical lesion of the genito-urinary organs, although, inoculation experiments are absolutely necessary to prove conclusively that a germ found in the urine is the specific bacillus of tuberculosis, nevertheless a bacillus that retains the carbol fuchsin stain after thorough decoloration with Pappenheim's solution is likely to be the tubercle bacillus. Disinfection of the urine and feces of tuberculous patients is required to free them from danger of transmission of the disease to others.

## THERAPEUTICS.

C. W. HEPBURN, M. D.

**The Treatment, General and Local, of "Cold in the Head."**—The foot-tub-hot-drink-quinine-opium-belladonna treatment for acute coryza does not appeal to Dr. Charles Prevost Grayson (Therapeutic Gazette, May 15, 1909), and in his practice he substitutes one of systemic sanitation which, if vigorously applied and conscientiously seconded by the patient, will, in most cases, speedily effect a cure. He gives the following as the treatment for a case presented within the first 24 hours of its course. Begin by giving the patient a cathartic dose of one of the natural saline waters. He should fast for 24 hours, and several times during this period he should for 15 to 20 minutes indulge in the most active exercise of which he is safely capable. With appropriate modifications this advice applies not only theoretically but practically to men, women, and children, and if in this way the heart's action is quickened and invigorated and the skin, bowels, and kidneys urged to active eliminative work, the engorgement of the nasal membrane will rapidly subside and its effects be quickly obliterated. If drugs must be used to fortify the patient's confidence, let them be only such as will harmonize with the foregoing therapeutic plan —the salicylates or their synthetic substitutes, the saline laxatives on rising and retiring, a few minims of aromatic spirit of ammonia or tincture of nux vomica. If active exercise be contraindicated by old age or some organic unsoundness, the cabinet bath or some other non-depressant method of promoting diaphoresis may be employed. Local treatment is merely palliative and supplementary to the above.

Reduce the oversensibility of the hyperemic nose by a preliminary spray of a 1 or 2 per cent solution of cocaine. Not more than what will amount to 2 or 3 drops of this should be used in each fossa, and within a half minute not only will the lower turbinates be less sensitive, but they will have shrunken sufficiently to permit inspection of the middle ones. If a small tuft of cotton on a light and slender applicator be now moistened with the 2 per cent cocaine solution, carried up to the middle turbinates, along their lower borders and into the recess of the middle meatus, we will in a few moments be enabled to reach and flush almost the entire nasal chamber with an alkaline antiseptic wash. When this has been accomplished it only remains to cover the mucosa with a protective and soothing fluid or powder.

**Treatment of Infantile Summer Bowel Disorders.**—To American Journal of Clinical Medicine for August, 1909, Dr. W. C. Post contributes, in a few clear-cut sentences, his method of combating the summer bowel disorders of infants as follows: "Stop all feeding for twenty-four hours, or longer if needed. Allow plenty of cool water for drinking in the interim. Clean out thoroughly by saline enemas and purgatives with broken doses of calomel followed by either salines or castor oil. Begin on second or third day to feed egg-albumin water, fruit juices in water and finally carbohydrate gruels, not returning to milk feeding until bowels are right. Neutralize toxins by intestinal antispetics (sulphocarbolates by preference). Control excessive peristalsis by codeine sulphate, fever by aconitine and restlessness by hyoscyamine. Keep room cool, dark and quiet. Promote convalescence by nuclein and brucine as tonic if needed." And crisply adds: "This will do the work, cito, tuto et jucunde. That's my experience—make it yours."

**Iodoform and Ichthyol in Pulmonary Tuberculosis.**—Dr. Samuel Floersheim, in Medical Council for August, 1909, says that after more than four years of study and pains taking observations he believes he can safely state that in iodoform and ichthyol we have therapeutic agents which are of exceedingly great value in the treatment of pulmonary tuberculosis. The initial dose of iodoform is from one-half to one grain with one or two drops of ichthyol added. These are put into capsules and administered three times a day. The dose of iodoform is increased each week until tolerance is established. The ichthyol is also increased until he dose reaches four drops three times a day. When the maximum dose of iodoform has been reached, continue it for one or two weeks and reduce it to one-half the dose for two weeks; then again gradually increase it to the maximum dose, and repeat as above stated. With the administration of the drugs the usual strict hygienic, dietetic and climatic measures must be observed. In many cases, after a few weeks of this treatment, the patients feel better, can eat and sleep better, feel stronger and brighter and gain rapidly in weight. Their cough becomes less distressing, the constriction about the chest less annoying, and the respirations deeper and freer. The author reports two of his cases in which he obtained the most striking effects from the treatment.

**Treatment of Pulmonary Tuberculosis with Ichthyol.**—Merck's Archives for July, 1909, publishes a paper read by Dr. William Odell at the National Tuberculosis Conference in London, last February, in which he gives the results of the treatment of 123 patients at the Western Hospital for Incipient Consumption, Torquay, by mean of ichthyol. This remedy has now been successfully employed for several years in the treatment of tuberculosis,. Although any direct action of the medicine on the germs of the disease may be considered excluded, it has been proved by numerous trials that the internal administration of ichthyol promotes nutrition, retards the waste of albumen, stimulates digestion, and increases the appetite, thus altogether raising the strength of the patient and renovating the powers of resistance of the enfeebled organism. He first commenced treating his patients with ichthyol in October, 1901, and, of the 123 cases treated since then, the disease was arrested in 29, 47 were very much improved, 12 much improved, 18 improved, 5 were incurable, 2 unsuitable, 5 unimproved, 1 died, and 4 are still in the hospital doing well. In 66 cases both lungs were affected; in 21 the right lung only; in 7 the left lung only; in 14 the right was decidedly affected, with slight impairment of respiratory murmur on the left; and in 15 the left was decidedly affected, with slight impairment of respiration on the right. The ages of the patients varied from 15 to 50, but the greater number were between 18 and 30 years of age, and the proportion of males and females pretty equally divided. The average length of time the patients remained in the hospital was three months, it being a rule that no patient should remain longer than four months, except by special recom-

mendation of the physician in charge. The patient who died succumbed to tubercular meningitis, which came on a month after his admission, and terminated fatally in ten days. The five discharged as incurable, and the two as unsuitable, were patients in the advanced stage, who never should have been sent to a hospital for incipient consumption. He usually commences with 7½ min. of ichthyol in half a wine-glass of water, three times a day, after food, and gradually increases it up to 10 drops, thrice daily, and has never gone beyond that dose, though no doubt, much larger doses would be tolerated in many cases.

**Guaiacol in Its Relation to Therapeutics.**—In Utah Medical Journal for July, 1909, Dr. E. L. Thorn presents a paper which he largely devotes to the discussion of the remarkable effects produced by the local application of guaiacol. He says he cannot call to mind any drug having equal power of penetration, or yielding such prompt results, upon application to the skin. The applications have been made upon various portions of the integument without any noticeable difference in results, and one strong recommendation in favor of its employment by this method is that, when used within reasonable limits, it relieves the stomach from the burden of distribution and avoids possible danger from depression of the circulation and respiration and from renal irritation. It is readily and rapidly absorbed by the skin, has the power of reducing excessive temperature and has been made use of in tuberculosis, erysipelas, pneumonia, articular rheumatism, scarlatina, sciatica and typhoid fever. The reduction of temperature is accompanied by free prespiration. It may be employed in place of baths in any of the continued fevers with corresponding results in the control of temperature. It is especially adapted to the treatment of typhoid fever in private practice, where bathing facilities are not as well provided for, as a rule, as in hospitals. Eight or ten drops well rubbed into the skin at intervals of four or five hours will easily maintain a temperature of 101 or 102 in a large proportion of such cases. There is no evidence that the medicine modifies the duration of the disease or the nervous complications. In inflammatory rheumatism, where the joints are swollen and painful, eight or ten drops rubbed into the skin at intervals of four or five hours will soon manifest its beneficial effects. Where a number of joints are involved simultaneously the applications should be made alternately, usually selecting the one that is most painful for each application. In concluding the author remarks that since his first use of this drug he has not had an opportunity to try it in sciatica, or other continued forms of neuralgia. However, judging from its properties and effects, together with the rapidity of its absorption by the skin, there is apparently sufficient ground for the theory that much might be accomplished in the way of relief, not alone in sciatica, but in supra-orbital neuralgia, and in neuralgia involving other branches of the fifth nerve, or other nerves which have proven rebellious to other modes of treatment.

**Adrenalin Therapy.**—The active principle of the suprarenal gland has been called by many an alkaloid, says Floersheim (Am. Med). It cannot be viewed in this light for the same reason that one would not call pepsin, the alkaloid of the stomach. The pepsin is to the stomach as adrenalin is to the adrenal gland. Adrenalin extract is actually a ferment derivative. It is best known and most conveniently employed in solutions of 1-1,000 to 1-20,000, administered with sterile water according to the needs. It may, however, be used with sterile solutions of cocaine or boric acid, but never with solutions containing metallic salts, oxidizing preparations, or strong alkalies, as these are incompatible. It has been employed locally, internally, by the stomach, subcutaneously and intravenously, and also as a nasal application, in suppositories for rectal administration, in ointment and in tablet form. Authorities differ as to the manner of its action; some maintain that it acts through the sympathetic nervous system, others that it acts through the vasomotor mechanism, others again that it acts directly on unstriped muscular fibers. A like difference of opinion exists, among those who have made experiments with it upon animals as to changes it produces in the constituents of the blood and as to degenerative changes it may produce in the heart, arteries, kidney, and liver. Adrenalin has been chiefly used to stop hemorrhage from the nose, lungs, stomach, etc., from whatever cause; it has been used with success, as an astringent, in inflammation of the tonsils and larynx, in hay fever and in conjunctivitis, iritis, etc. It is also a powerful cardiac stimulant, sometimes giving results when strychnin, digitalis, sparteine and the like fail to benefit. Brodie states that it is an antidote to chloroform narcosis. Its other uses are myriad and cannot be enumerated here, but we understand the author's enthusiasm when he declares that the introduction of suprarenal-

al substance within the last decade as a therapeutic agent in the treatment of disease marks an epoch in scientific therapeutics.

When a pyloric carcinoma is palpable, preoperatively radical removal is usually impossible.—Amer. Jour. of Surg.

**Diagnosis of Early Carcinoma of the Breast.**—Whatever individual theory we may have as to the etiology of cancer, says Dr. Adolph Bonner, in (Post-Graduate for Feb., 1909), we must recognize that carcinoma in its earliest invasion is a local condition with the tendency to become systemic in character, and that its prognosis depends not only up the surgical interference, but more so upon how early in the disease operation is undertaken. For diagnostic purposes and as possible exciting factors, the history of heredity, previous existence of disease and subsequent surgical interference therefore, or the definite history of long continued mechanical irritation or that of a severe trauma, should all be given due consideration in the order of their importance as possibly pointing towards the malignancy of the tumor under examination. More important than the above is the age of the patient; for what is termed the cancerous age, coincides with the retrogression of physiologic functions: that is, at the climacteric period. In making the diagnosis we must remember that by far the greatest number of breast tumors are malignant; that growing tumors after 30, and especially between the ages of 40 and 50, should be looked upon with suspicion; that pain is not a very early sign of carcinoma; that when a pre-existing tumor of long standing takes on a sudden exacerbation of growth it is strongly suspicious of carcinomatous degeneration; that immobility of the tumor with ill-defined borders, favors the diagnosis of malignancy; that, though retraction of the nipple may occur in chronic atrophic mastitis, when such retraction is met, it is strong presumptive evidence of malignancy. On the other hand, the absence of a retracted nipple does not contraindicate the existence of malignancy, as in such cases the tumor will be found at a distance from the nipple. Lately, Wyle and Crile have drawn attention to the question of hemolysis as an aid in the diagnosis of this condition. The author cannot speak from personal experience, but adds that, in following recent literature, one is impressed with the impossible value of this form of examination, and from present indications much may be hoped from it.

# SOCIETY PROCEEDINGS

## PRELIMINARY PROGRAM

*Thirty-fifth Annual Meeting of the Mississippi Valley Medical Association at the Southern Hotel, St. Louis, Mo., October 12, 13, 14, 1909.*

### OFFICERS, 1909

President, J. A. Witherspoon, Nashville, Tenn.

First Vice-President, Louis Frank, Louisville, Ky.

Second Vice-President, Albert E. Sterne, Indianapolis, Ind.

Secretary, Henry Enos Tuley, Louisville, Ky.

Treasurer, Samuel Cecil Stanton, Chicago, Ill.

### COMMITTEE OF ARRANGEMENTS

Chairman, Louis H. Behrens;
Ways and Means, Henry Schwarz;
Entertainment, C. M. Nicholson;
Reception, John Young Brown;
Press, Thos. A. Hopkins;
Hotels, Frank Hinchey;
Ladies, Frances L. Bishop;
Registration, Henry J. Scherck;
Exhibits, Louis H. Behrens;
Clinics, Herman Tuholske;
Treasurer, J. H. Amerland;
Badges, Wm. E. Sauer.

### PROGRAM

Address of President, J. A. Witherspoon, Nashville, Tenn., Medical Education, Past, Present and Future.

Address in Medicine, Sherman G. Bonney, Denver, Colo., Mistakes in Medical Practice.

Address in Surgery, John B. Deaver, Philadelphia, Pa., Modern Surgery of the Digestive Tract.

### SYMPOSIUM

S. P. Beebe, New York City, Medical Treatment of Exophthalmic Goitre.

George W. Crile, Cleveland, O., Post-Operative Results in Exophthalmic Goitres and Tumors.

J. H. Jacobson, Toledo, O., Bi-lateral Ligation of the Upper Poles of the Thyroid Gland for Basedow's Diseases.

Allen B. Kanavel, Chicago, Ill., in association with Lewis J. Pollock, Chicago, Thyroidectomy in the Treatment of Catatonic Dementia Praecox; A final report of the results in a series of twelve cases.

Albert J. Ochsner, Chicago, Ill., Surgical Treatment of Exophthalmic Goitre.

Discussion opened by Herman Tuholske, St. Louis, and Arthur R. Elliott, Chicago, Ill.

PAPERS

Isasac A. Abt, Chicago, Ill., Use of Cathartic Drugs in Infancy.

Maynard A. Austin, Anderson, Ind., The Socialistic Future of Medicine.

Charles E. Barnett, Fort Wayne, Ind., Genital Canal Block Following Neisser Coccus Infection. Discussion opened by Alexander S. Wolf, St. Louis.

Channing W. Barrett, Chicago, Ill., The Treatment of Peritoneal Infections in the Light of the Protective Nature of Peritonitis.

L. W. Bremerman, Chicago, Ill., Methods of Estimating the Renal Function and their Relation to Surgery.

George V. I. Brown, Milwaukee, Wis., The Surgical Treatment of Cleft Palate, Continued Report with Illustrations.

J. H. Carstens, Detroit, Mich., What Women Should Know in Regard to Uterine Cancer.

A.H. Cordier, Kansas City, Mo., Elements of Success in Surgical Work. Discussion opened by Duncan Eve, Nashville, Tenn.

Leo M. Crafts, Minneapolis, Minn., The Problem of the Insane and Defective.

Jos. Rilus Eastman, Indianapolis, Ind., Sarcoma of the Prostate.

Frank Parsons Norbury, Jacksonville, Ill., Secondary Cancer Affecting the Spinal Cord, with report of cases.

F. M. Pottenger, Monrovia, Cal., Diagnostic Aids in Tuberculosis, Muscle Rigidity and the Orthodiagraph.

B. M. Ricketts, Cincinnati, O., Local Versus General Anesthesia.

Nathan Rosewater, Cleveland, O., Atony and Tonics.

C. N. Smith, Toledo, O., The Latent Gall Stone.

Willard J. Stone, Toledo, O., The Latent Duodenal and Gastric Ulcer.

Discussion opened by A. C. Croftan, Chicago, Ill.

J. A. Stucky, Lexington, Ky., Some Reflexes Neuroses Arising from Nasal Abnormalities.

Edwin Walker, Evansville, Ind., Acute Dilatation of the Stomach. Discussion opened by Jesse S. Myers, St. Louis, Mo.

H. O. Walker, Detroit, Mich., Pfannenstiel Incision, with Report of Cases.

Alex. C. Wiener, Chicago, Ill., Tuberculous Toxemia in Surgery.

Daniel N. Eisendrath, Chicago, Ill., Sigmoid Diverticulitis. Discussion opened by Robert Edw. Wilson, St. Louis, Mo.

Earl M. Gilliam, Columbus, O., A New Method of Dealing with Urethro-cervical Fistula. Report of Case.

M. L. Heidingsfeld, Cincinnati, O., Bullous Vaccinal Dermatitis.

C. F. Hoover, Cleveland, O., Arterial Sclerosis.

C. W. Stiles, Washington, D. C., The Hook Worm Disease.

Passed Assistant Surgeon C. H. Lavinder, Marine Hospital Service, Pellagra.

J. J. Watson, Columbia, S.C., Pellagra.

E. Mark Houghton and H. S. Yntema, Detroit, Mich., Some Comparisons of the Physiological Action of Preparations of the Heart Tonics of the Digitalis Series.

John A. Landis, Cincinnati, O., Alcohol. Discussion opened by Marc Ray Hughes, St. Louis, Mo.

G. Frank Lydston, Chicago, Ill., The Russianizing of the American Medical Profession.

Milton H. Mack, Chicago, Ill., The Macroscopical Appearance of the Stomach Contents as a Diagnostic Aid in Stomach Diseases.

A. H. Barkley, Lexington, Ky., Report of Burn, Where One Half of the Body Area Was Involved With Recovery; Exhibition of Patient.

R. Alexander Bate, Louisville, Ky., Therapeutic Renaissance.

E. O. Smith, Cincinnati, O., The Treatment of Urethral Strictures.

Louis H. Warner, Brooklyn, N. Y., Actualities of Bacterial Vaccine Treatment.

S. C. Stanton, Chicago, Ill., Camp Sanitation. Discussion opened by Passed Assistant Surgeon B. S. Warren, St. Louis, Mo.

Geo. Allen Staples, Dubuque, Ia., Some Pediatric Cases found in General Practice.

D. O'rasy Hecht, Chicago, Ill., The Treatment of Neuralgias by Deep Injections and its Limitations.

J. Rawson Pennington, Chicago, Ill., The Rectal Circle or Zone of Rectal Pathology.

Willard D. Haines, Cincinnati, O., Surgery of the Gall Bladder.

Charles Carter, Clinton, Ill., Infant Feeding in Country Practice.

Florus F. Lawrence, Columbus, O., Mortality and Morbidity of Abdominal Surgery.

H. Horace Grant, Louisville.

Liston Homer Montgomery, Chicago, Ill. A Proposed Federal Health Department.

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For the diagnosis of fractures of the upper end of the femur careful measurements are often of greater value than any manipulations—and much safer.—Amer. Jour. of Surg.

## MEDICAL SOCIETY OF THE MISSOURI VALLEY.

The twenty-second annual meeting of this association, held in Council Bluffs, Iowa, under the presidency of Dr. C. B. Hardin, of Kansas City, on September 9 and 10, was most successful both from a scientific and social standpoint, a number of notable guests being present. The orations and papers were above the average, and the discussions interesting. We hope to present our readers with a synopsis of the proceedings in our next issue. The election of officers for the ensuing year resulted as follows: President, Dr. A. B. Somers, Omaha; vice-presidents, Dr. C. R. Woodson, St. Joseph, and Dr. Flavell B. Tiffany, Kansas City; treasurer, Dr. T. B. Lacey, Council Bluffs (re-elected); secretary, Dr. Chas. Wood Fassett, St. Joseph (re-elected). Omaha was chosen as the place of meeting in March, 1910.

## AMERICAN PROCTOLOGIC SOCIETY.

*Eleventh Annual Meeting, held in Atlantic City, June 7 and 8, 1909.*

(Continued from page 366.)

**"Sir Charles Ball's Operation for Internal Hemorrhoids,"** was the title of a paper read by G. W. Combs, M.D., Indianapolis, Ind., in which he briefly described the operation advised by Mr. Ball for the removal of internal hemorrhoids which consists: (1) of making a curved incision opposite the pile being treated, terminating in the mucous membrane on either side of the pile, the greatest convexity not including more than one-third of the revoluted anal ring; (2) of bluntly dissecting the pile from the external sphincter, the dissection being carried upward until healthy mucous membrane is reached; (3) of crushing the pedicle in a powerful clamp; (4) of passing a heavy silk ligature subcutaneously in the remaining two-thirds of the revoluted anal ring and through the crushed mucous membrane pedicle, one part of which is constricted in a first tying and the whole of it in a second; (5) of tying the ligature very tightly, thus bringing the remaining two-thirds of the revoluted anal ring up into position, maintaining it there until union takes place and constructing the pedicle so that sloughing will occur. The results obtained by the writer have not been so favorable as those that should follow the procedure as indicated by the author. The following are the writer's conclusions: 1. The post-operative pain is greater than after the usual ligature or clamp and cautery method. 2. The duration of the healing period is not shortened because of the sloughing of the ligature from either the skin or pedicle before union takes place, leaving the wounds to heal by granulation. 3. The is a necessity for unusual watchfulness that all ligatures may be removed as they slough. 4. Failing to secure primary union, skin-tabs frequently remain for subsequent removal. 5. No time is saved by this modification of the ligature operation. 6. There is danger of secondary hemorrhage from an early tearing off of the pedicle by traction.

**"The Technic of the Injection Treatment for Hemorrhoids"** was the title of the paper by Dr. Edwin A. Hamilton, of Columbus, O., who stated that the injection treatment does not have a wide application; as its indiscriminate use is followed by embolus, abscess and other complications, and relapses are prone to occur except in cases especially adapted to this method. The instruments needed are a cone-shaped anal speculum with one broad fenestrum and a special copper-tipped long needle of large caliber with an outside barrel which may be screwed to the needle proper to regulate the depth to which it may be inserted. The solution is 10 per cent carbolic acid, 90 per cent oil of sweet almonds. Neither water nor glycerine is used in the solution as they cause pain. When the sphincter is normal or hypertrophied, the hemorrhoids are never strained outside of the rectum and treated there, but are allowed to protrude through the fenestrum of the speculum and attended to in their normal location. In cases where the sphincter is dilated and the hemorrhoids are easily replaced, they may be treated outside, but under no other conditions. From four to eight drops are injected in hemorrhoid, only one injection being made at one treatment. The patient rests in the recumbent posture for several minutes. No application or dressing is applied. The bowels are moved after the second day, Subsequent treatments may be administered at intervals of five days.

**The Test Diet; Nitrogen and Sulphate Partitions, as an Aid to Diagnosis in Intestinal Disturbances.**—(Jerome M. Lynch, M. D., New York City, N.Y.)—Who stated that the subject of test-diet, as suggested by Professor Schmidt, is one well worthy of study. If, after a proctoscopic examination of rectum and sigmoid, and an examination of the stomach contents, a case is still obscure, the test-diet should be given, and an examination of the feces and a

thorough examination of the urine, with nitrogen and sulphate partitions, be made. Otherwise one cannot conscientiously say he has exhausted all the resources at his command. These tests, he admitted, are not always conclusive, but in most cases they are of great help; often a positive solution of doubtful problems. Of twenty-five cases under observation during the last six months, he found three of especial interest. Case I was referred for treatment on account of moderate diarrhea, with prolapsing and bleeding internal hemorrhoids. The stomach had been previously examined with negative results. Proctoscopic examination, except for hemorrhoidal condition was negative. Put on test-diet. The specimen of feces examined had a somewhat pasty consistency, a light yellow color, normal odor and showed no macroscopic admixture. Microscopic examination showed the usual amount of striped muscle fiber, carbohydrate food remnants and granular detritus, with an excess of free fat and fatty acids. The starch was properly digested, bacterial flora not excessive; reaction, neutral. Sublimate test, negative. Fermentation test, negative. The specimen showed evidence of deficient bile admixture. The analysis of a twenty-four-hour specimen of urine showed the specimen to contain no albumen and no renal elements, with a normal daily amount of urine, a normal specific gravity and a normal daily excretion of urea. The sulphate ratio as well as the ratio of the urea and uric acid was somewhat depressed, with the presence of a marked excess of indican. Analysis of this report disclosed at once the cause of the diarrhea, namely, deficiency of bile with excess of fatty fluids and depressing of sulphate ratio, causing auto-intoxication. The other two cases were equally interesting. Relative to the determination of the clinical significance of faulty sulphate and nitrogen partition, the writer stated that the relative increase in ethereal sulphate may be due to one of several causes, among which were mentioned, stasis in the bowel, ingestion of decomposing nitrogenous food, improper digestion of food in the stomach and upper intestine, by dimunition or absence of hydrochloric acid and bile, the result of excessive or faulty bacterial fermentation in the lower portion of the small intestine and the upper portion of the large intestine. This process may exist without an actual toxemia, and an actual toxemia may exist without this particular putrefactive process, but they are usually associated. Excess of ethereal sulphate is usually associated with an excess of endoxyl sulphate, though not always. Without means of estimating the amount of the actual products of toxemia, the relative excess of the real sulphates is used as a guide, although subject to errors, as are other guides. Fault in the nitrogen partition would seem to justify the inference that the hepatic function is disturbed. The decrease in the relative amount of urea nitrogen probably indicated the degree of the fault. With this decrease, there is a relative increase in the amount of one or more of the other forms of nitrogen in the urine. In the severe toxemias of pregnancy, pneuomnia, etc., this is chiefly in ammonia nitrogen and creatinin nitrogen; in digestive disturbances the increase in the so-called extractive nitrogen, and in lithemic cases and in those of cyclic vomiting, headache, or albuminuria, in the purin nitrogen as well, particularly during the acute attack. In cases of enteritis or colitis, owing to the destruction of cells, the purin nitrogen is often increased. Faulty nitrogen partition may exist without a toxemia but a hepatotoxemia without a faulty nitrogen partition is practically unknown. Acidosis frequently accompanies a faulty nitrogen partition; but it would seem an evidence of the toxemia rather than of the fault in hepatic function, though this is disputed by some.

**Multiple Adenomata of the Rectum.**—(James P. Tuttle, M.D., New York City.)—Who stated that the distinction between multiple adenomata and polypi is more marked clinically, than histologically. Pedunculated adenomata or polypi may exist in varying numbers without constituting a true multiple adenomata. Age and its relation to the two types; distinction between the two types in proportion to the number of growths; the relative frequency of the growths in different portions of the bowel; growths found largely in the sulci and not in the mucous folds of the bowel. What is the probability of malignant metamorphosis when not interfered with? The tendency to recurrence, in malignant form, after surgical measures. Results of internal and local medication; results of functional rest to the parts. Does radical operation furnish the best hope for the patient, in view of clinical experience?

(To be continued.)

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When a patient with inflamed varicose veins develops suddenly dyspena and cyanosis, don't sit her up to examine her—the probability of pulmonary embolism is too great.—Amer. Jour. of Surg.

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## MEDICAL MISCELLANY

**An Important Little Work on Biological Therapeutics.**—In view of the near approach of the season when biological therapeutics will claim a considerable share of the attention of practitioners, reference may pertinently be made at this time to a unique and valuable contribution to the subject which has recently issued from the press of Messrs. Parke, Davis & Co. The publication consists of 52 pages, exclusive of the cover, and appears in brochure form. It is handsomely printed on white enamel paper of first quality and bears in colors a profusion of halftone illustrations. The title is "Serums and Vaccines." A brief chapter on the origin and development of biological therapeutics, with an interjected hint as to what the opsonins may have in store for us, constitutes the introduction. Then follow chapters on serums—anti-diphtheric, antitetanic, antistreptococcic, antigonococcic, antitubercle and antivenomous; on tuberculins; on vaccines, including the new bacterial vaccines which are exacting so much attention from the medical world; on organo-therapy, its development, and some of the important products that are associated with it—"a tabulation," in the language of the brochure itself, "of such creations of biologic pharmacy as are really utilizable in medicine." There are striking pictures of the company's home laboratories at Detroit, with numerous interior views; the research laboratory; the operating house and biological stables at Parkedale Farm (where the animals are cared for), with accompanying landscapes in nature's colors. This little book, "Serums and Vaccines," is distinctly "worth while." If you haven't seen a copy, drop Parke, Davis & Co., a postal card at their home offices in Detroit, mentioning this journal, and get one. It is a safe guess that any physician who receives the brochure will read it admiringly and with interest, filing it away thereafter for future reference.

A young and apparently healthy man with tendo-synovitis should always be suspected of gonorrhea.—Amer. Jour. of Surg.


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